

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7367

CERTIFICATE OF DEATH

07363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WORCESTER</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL and give nearest town</i>		c. LENGTH OF STAY IN 1b <i>1 week.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>West Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Zuzanna</i>	Middle <i>Adams</i>	Last <i>Adams</i>	4. DATE OF DEATH <i>June 11 1958</i>	Month <i>June</i>	Day <i>11</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 1 1886</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR <i>Months</i>	IF UNDER 24 HRS. <i>Days</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Over Home</i>		11. BIRTHPLACE (State or foreign country) <i>RIGA, LITHUNIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN SKIERS</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mrs. Raymond Joseph, Berlin MD</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>	
332X		DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Salisbury, Md</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Salisbury, Md</i>	
ACTUAL SIGNATURE <i>W. G. Ellis Jr.</i>		M.D.				DATE SIGNED <i>6-13-58</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/14/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>EVOROLEGN</i>		22d. LOCATION (City, town, or county) <i>BERLIN</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna Q. Burley Berlin Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUN 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Abelsoch</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c. 3, 8, 9 File G231 7-8-58 et

7419

CERTIFICATE OF DEATH

07364

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN lb 10 85 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS X Nanticoke	
f. FIRST MIDDLE LAST AUSTIN MUSON ALBRIGHT		4. DATE OF DEATH Month Day Year 6/10/58 19	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/58 1869	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Veteran		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Emsley Albright		14. MOTHER'S MAIDEN NAME Elizabeth Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Spanish American & World War #1	
17. INFORMANT Mrs Pearl Albright, Md.		Address Nanticoke	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
DUE TO 420.0			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease		16 Years	
DUE TO (c) Generalized Arteriosclerosis		10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 April 1958 to 10 June 1958 , that I last saw the deceased alive on 10 June 1958 , and that death occurred at 5 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Richard H. Saunders ADDRESS (Street, city or town, state) Nanticoke, Md. DATE SIGNED 6/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58	
22c. NAME OF CEMETERY OR CREMATORIUM Wic. Mem. Park Cem.		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
22e. FUNERAL DIRECTOR'S SIGNATURE Corinne L. Spivak		22f. ADDRESS Bivalve, Md.	
22g. REC'D BY REGISTRAR JUN 17 '58		22h. REGISTRAR'S SIGNATURE Alleson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07365

CERTIFICATE OF DEATH

Reg. Dist. No.

7368

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Hazel Ave		d. STREET ADDRESS 232 Hazel Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELMER	Middle BRAXTON	Last BAKER	4. DATE OF DEATH JUNE 6th 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0 Days 26 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator of Concrete Block Co.		10b. KIND OF BUSINESS OR INDUSTRY Concrete Block Co.		11. BIRTHPLACE (State or foreign country) Whaleyville	
13. FATHER'S NAME Ulysses R. Baker		14. MOTHER'S MAIDEN NAME Annie Adkins		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Mr. Gordy Parker (Niece) Address Salisbury, Maryland		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 30 min	
		Coronary Artery Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, February 1958 , to _____, June 6, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.				ADDRESS (Street, city or town, state) Pine Bluff Road Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery	
22d. LOCATION (City, town, or county) Salisbury, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE Alf. Leach	

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AT 320WTA-174310 TEMP 180 DAT 9441AM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7369

CERTIFICATE OF DEATH

07366

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>MARYLAND</i>		b. COUNTY <i>DORCHESTER</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Vienna</i>		d. STREET ADDRESS <i>09x-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Ether</i>	Middle <i>Bassett</i>	Last <i>Bassett</i>	4. DATE OF DEATH <i>June 7 1958</i>	Month <i>June</i>	Day <i>7</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/9/1881</i>		9. AGE (In years 100 birthday) yrs. <i>77</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Bassett</i>		14. MOTHER'S MAIDEN NAME <i>Margie Christopher</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>Mississippi Bassett, Vienna</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Myocardial infarct</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Vienna</i>		20f. (City or town) <i>Vienna</i>		(County) <i>Vienna</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>6-3</i> , 19 <i>57</i> , to <i>6-7</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-7</i> , 19 <i>58</i> , and that death occurred at <i>49</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Salisbury, Md</i>		DATE SIGNED <i>6-7-58</i>	
ACTUAL SIGNATURE <i>W.B. Ellis</i>		M.D.							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/9/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Vienna</i>		22d. LOCATION (City, town, or county) <i>Vienna</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth J. Walloughby, East Kent Mort.</i>		ADDRESS <i>100 W. Main St., Salisbury, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 16 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Asst. Health Officer</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07367

7370

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TEN. GEN. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES William Bennett</u>		First <u>Charles</u>	Middle <u>William</u>
4. DATE OF DEATH <u>June 28 1958</u>		Month <u>June</u>	Day <u>28</u>
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Aug 12, 1881</u>		9. AGE (in years (<u>76</u>) at birthday) yrs. Months <u>0</u>	10. IF UNDER 1 YEAR Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COUNTRY TREASURE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
10c. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL W. BENNETT</u>		14. MOTHER'S MAREN NAME <u>SALLIE E. VENABLES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or name) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CHARLES W. BENNETT, Jr. - Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Arteriovenous Accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerosis.</u> DUE TO <u>260X</u> (c) <u>Mild diabetes + Hypertension</u> 10 days 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>260X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>June 10, 1958</u> to <u>6/28 1958</u> , that I last saw the deceased alive on <u>6-28 1958</u> , and that death occurred at <u>2:57 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. B. Smith</u>		ADDRESS (Street, city or town, state) <u>Med. Center Hwy Md. 625k55</u>	
DATE SIGNED <u>6-28-58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wm. B. Smith, SALISBURY, MARYLAND</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>PARSONS CEMETERY</u>	
22d. LOCATION (City, town or county) <u>Salisbury, Md.</u>		(State) <u>Maryland</u>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 6/30/1958		22f. DATE THEREOF <u>6/30/1958</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co., Salisbury, Md.</u>		24a. ADDRESS <u>George C. Neff</u>	
		24b. REC'D BY REGISTRAR DATE JUL 1 '58	
		24c. REGISTRAR'S SIGNATURE <u>John E. Neff</u>	

DEPARTMENT OF HEALTH - DIVISION OF MEDICAL EXAMINERS
CERTIFICATE OF DEATH

NAME OF DECEASED		ADDRESS	
JAMES M. HARRIS		101 E. 10TH ST.	
AGE		SEX	
65		M	
DATE OF BIRTH		DATE OF DEATH	
APRIL 21, 1888		APRIL 21, 1953	
CAUSE OF DEATH		METHOD OF DEATH	
COPD		NATURAL	
TIME OF DEATH		TIME OF AUTOPSY	
12:00 P.M.		12:00 P.M.	
NAME OF DOCTOR		NAME OF HOSPITAL	
DR. JAMES M. HARRIS		HOSPITAL OF THE CITY	
RELATIONSHIP TO DECEASED		NAME OF ATTENDING PHYSICIAN	
WIFE		DR. JAMES M. HARRIS	
SIGNATURE		SIGNATURE	
JAMES M. HARRIS		DR. JAMES M. HARRIS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07368

7371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Pen Gen. Hosp				d. STREET ADDRESS Lillian St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA		First	Middle AMELIA	Lost BISHOP	4. DATE OF DEATH JUNE 5 th	Month JUNE	Day 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1891	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Mardeala Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John George Pollitt		14. MOTHER'S MAIDEN NAME Mary Elizabeth Bailey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Carl William Pollitt (Brother) Hebron Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO		Coronary Occlusion Arterio sclerotic heart Disease		INTERVAL BETWEEN ONSET AND DEATH Dyur	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-17, 1956, to 6-5, 1958, that I last saw the deceased alive on 5-12, 1958, and that death occurred at 421 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Earl Royer M.D.						ADDRESS (Street, city or town, state) Dr. Earl L. Royer 407 Camden Ave. Salisbury Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Hebron Cemetery		22d. LOCATION (City, town, or county) Hebron, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE O. L. Edrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7372

Item 9 Film 0230 6-11-58 et

Reg. Dist. No.

07369

1. PLACE OF DEATH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Salisbury		c. LENGTH OF STAY IN lb 2 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		d. STREET ADDRESS 427 Penn. Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Howard		First Clifton	Middle Bounds	Last Bounds	4. DATE OF DEATH June	Month 3	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1891	9. AGE (In years lost birthday) 67 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Tobacco CONFECTIONERY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME James Bounds		14. MOTHER'S MAIDEN NAME Ann Elizabeth King						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or print unknown) No		16. SOCIAL SECURITY NO. 817-10-3519		17. INFORMANT Mrs. Alice A. Bounds		Address same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 18 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Myocarditis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19____, to June 3, 1958, that I last saw the deceased alive on June 3, 1958, and that death occurred at 9:03 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Philip A. Insley M.D. ADDRESS (Street, city or town, state) E. Main St., Salisbury, Md. DATE SIGNED 6-6-58								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/5/1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co/ Salisbury, Maryland		ADDRESS Brigitte C. Thrasher		24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE A. L. Edwards		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07370

7373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sabiney</i>		c. LENGTH OF STAY IN 1b <i>16 Days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
3. NAME OF DECEASED (Type or print) <i>OLLA</i>		First <i></i>	Middle <i></i>
4. DATE OF DEATH <i>Brittingham</i>		Month <i>JUNE</i>	Day <i>24</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug 5-1887</i>		9. AGE (In years last birthday) <i>79/10/17</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL/OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Houswife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	10c. BIRTHPLACE (State or foreign country) <i>Snow Hill, Md</i>
11. FATHER'S NAME <i>Baltimore Quiley</i>		12. CITIZEN OF WHAT COUNTRY? <i>Manie Bromly</i>	
13. MOTHER'S MAIDEN NAME <i></i>		14. INFORMANT <i>None</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i></i>	17. ADDRESS <i>McDevlin Brittingham, Snow Hill, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>200.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>Kulmoner, Metastasis + Effusion Lymphosarcoma</i>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6.8</i> , 19 <i>58</i> , to <i>6.24</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6.24</i> , 19 <i>58</i> , and that death occurred at <i>9:20 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Hal Brille</i>		ADDRESS (Street, city or town, state) M.D. <i>Medical Center</i> DATE SIGNED <i>6.24.58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 26/58</i>		22b. DATE THEREOF <i>Bates Methodist</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i></i>		22d. LOCATION (City, town, or county) <i>Snow Hill, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay E. Dennis, Snow Hill, Md</i>		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
24b. REGISTRAR'S SIGNATURE <i>Asst. Health</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07371

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								82									
FOR STATE HEALTH DEPT.												I									
3. NAME OF DECEASED (Type or print)				First WILLA		Middle AMELIA		Last CAREY		4. DATE OF DEATH JUNE 15th 19 58		Month Dey Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1894		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1YEAR Months 6 Days 17 Hours Min.		IF UNDER 24 HRS.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Chincoteague, Virginia				12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME Thomas M. Truitt				14. MOTHER'S MAIDEN NAME Della Kollock				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.									
17. INFORMANT Mr. Walter H. Carey (Husband) Pittsville, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) gave rise to underlying cause (a), stating the underlying cause last. DUE TO (c) FRACTURE OF ANKLE				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20c. TIME OF INJURY Hour a. m. 5-28 1958				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger auto collided w another car				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pittsville Wicomico Md									
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. ACTUAL SIGNATURE Earl L. Royer				DATE SIGNED June 16 1958									
EXAMINER'S NAME (Type) Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jun. 18, 1958				22b. DATE THEREOF Jun. 18, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Pittsville Cem. (Old Part) Pittsville, Maryland		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
VS. A15ME SM 2/57				24a. REC'D BY REGISTRAR DATE JUN 18 '58				24b. REGISTRAR'S SIGNATURE Audie Buck				23. FUNDAMENTAL PRINCIPLES OF MEDICAL EXAMINATION									

ВІДНОВЛЕННЯ ПІСЛЯ СТАРГО СТАДІОНА

ПІДСТАДІОН ВІДНОВЛЕННЯ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07372

7375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 Oak Dale Road		e. STREET ADDRESS 1 212 Oak Dale Road				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEAH		First LEAH	Middle CATHERINE	Last CLEARY	4. DATE OF DEATH JUNE 2 nd 1958	Month JUNE	Day 2	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1873	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work - Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Turner White		14. MOTHER'S MAIDEN NAME Emma Ennis							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Gladys Baysinger (Daughter) 212 Oak Dale Road - Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. Salisbury, Md.		20f. (City or town) Salisbury		(County) Wicomico	(State) Maryland
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE Fred R. Gramse				ADDRESS (Street, city or town, state) 402 S. Division St. Salisbury, Md.					DATE SIGNED June 19 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 9 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07373

7376 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sabreay</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		d. STREET ADDRESS <i>870 #1 Br. 37</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Ella Belle</i>	Middle <i>Collins</i>	Last <i>Collins</i>	4. DATE OF DEATH <i>June 11</i>	Month <i>June</i>	Day <i>11</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>MAY 6 1887</i>	9. AGE (In years last birthday) <i>71</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House wife</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Collins</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>		17. INFORMANT <i>Evelyn Allen Snowhill md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Gales Ferry Md</i>	(County) <i>Gales Ferry Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>6/5</i> , 19 <i>58</i> , to <i>6/11</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/10</i> , 19 <i>58</i> , and that death occurred at <i>Gales Ferry Md</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wilbur R. Glass</i> M.D. ADDRESS (Street, city or town, state) <i>Gales Ferry Md</i> DATE SIGNED <i>6-13-58</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-15-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Tinsley Chapel</i>	22d. LOCATION (City, town, or county) <i>Pocomoke, Md</i>		(State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New church, VA -</i>	ADDRESS <i>Edgar Wharton - New church, VA -</i>	24a. REC'D BY REGISTRAR DATE JUN 18 '58	24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07374

7420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown - Rural		c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sirman	Middle Fulton	Last Cook		
4. DATE OF DEATH Month June 8, 1958	Day 19	Year			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1909		
9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer	10b. KIND OF BUSINESS OR INDUSTRY Marvil Package Co.	11. BIRTHPLACE (State or foreign country) Wicomico Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Alberta Cook				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 222-01-0561	17. INFORMANT Mrs. Ruby Stanley, Mardela Springs, Md. RFD	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart failure Dilatation, + ecess to function Saw him just few days before death					
			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from 6/3/58 to 6/7/58 , that I last saw the deceased alive on June 7, 1958 , and that death occurred on 6/7/58 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mardela Springs, Md.					
ACTUAL SIGNATURE Z RED COOPER	DATE SIGNED				
PHYSICIAN'S NAME (Type) Z RED COOPER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 11, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Zion Church Cemetery	22d. LOCATION (City, town, or county) Near Sharptown, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland	ADDRESS J.J. Frampton and Son, Federalsburg, Maryland	24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE Alfred Cook	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - DIVISION OF STATE REGISTRATION - 16

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	60	M	HEART DISEASE
ADDRESS	AGE AT DEATH	TIME OF DEATH	TIME OF DEATH
100 E. 10TH ST., NEW YORK CITY	60	10:00 P.M.	10:00 P.M.
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF HOSPITAL	NAME AND ADDRESS OF FUNERAL DIRECTOR	NAME AND ADDRESS OF CEMETERY
DR. JAMES J. O'LEARY, 100 E. 10TH ST., NEW YORK CITY	HOSPITAL	WILLIAMS FUNERAL HOME, 100 E. 10TH ST., NEW YORK CITY	NEW YORK CITY CEMETERY
NAME AND ADDRESS OF PERSON REPORTING	NAME AND ADDRESS OF PERSON REPORTING	NAME AND ADDRESS OF PERSON REPORTING	NAME AND ADDRESS OF PERSON REPORTING
JOHN J. KELLY, 100 E. 10TH ST., NEW YORK CITY	JOHN J. KELLY, 100 E. 10TH ST., NEW YORK CITY	JOHN J. KELLY, 100 E. 10TH ST., NEW YORK CITY	JOHN J. KELLY, 100 E. 10TH ST., NEW YORK CITY
RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED
SPOUSE	SPOUSE	SPOUSE	SPOUSE
DATE OF DEATH	TIME OF DEATH	TIME OF DEATH	TIME OF DEATH
10/10/63	10:00 P.M.	10:00 P.M.	10:00 P.M.
NAME OF PERSON SIGNING	NAME OF PERSON SIGNING	NAME OF PERSON SIGNING	NAME OF PERSON SIGNING
JOHN J. KELLY	JOHN J. KELLY	JOHN J. KELLY	JOHN J. KELLY
POSITION	POSITION	POSITION	POSITION
ATTENDANT	ATTENDANT	ATTENDANT	ATTENDANT
DATE	DATE	DATE	DATE
10/10/63	10/10/63	10/10/63	10/10/63

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07375

Reg. Dist. No.

7377

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS 703 Alvin Ave.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CAROLYN	First SUE	Middle LOST	4. DATE OF DEATH JUNE 24 th 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18 1909
9. AGE (In years lost birthday) 48 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) Pocomoke, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Chesser		14. MOTHER'S MAIDEN NAME Laura Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Walter Paul Coppinger (Husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Metastatic Carcinoma any Radiation Effect DUE TO (c) Carcinoma of the Breast		19. INTERVAL BETWEEN ONSET AND DEATH 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30, 1958 to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 4:10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.		ADDRESS (Street, city or town, state) Dr. Thomas C. Hill Pine Bluff Rd Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Gates of Heaven -Silver Spring, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR JUN 27 '58		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87,390 METERS - STAFFA TO DUNTRASSI STATE QUALITY RAMP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08509

7421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs-Rural Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mardela Springs - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo		d. STREET ADDRESS San Domingo	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ode Royal Cornish		First	Middle
		Last	Cornish
4. DATE OF DEATH June 26 1958		Month	Day
		Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1890
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cornish		14. MOTHER'S MAIDEN NAME Jane Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Ella Cornish, Mardela Springs, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidemical Carcinoma of Bladder DUE TO 1810			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1957 , to May 1958 , that I last saw the deceased alive on May 22 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Raymond M. Yow		ADDRESS (Street, city or town, state) 707 Camden, Salisbury, Md. 21801	
PHYSICIAN'S NAME (Type) Raymond M. Yow, M.D.		DATE SIGNED 7-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR JUL 14 '58	
		24b. REGISTRAR'S SIGNATURE Aut. Search	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07376

7422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 135 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg		d. STREET ADDRESS 09 x 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Darcy	Middle William	Last Coulbourne	4. DATE OF DEATH July 20, 1894	Month June	Day 4	Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 20, 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canning Factory		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Coulbourne				14. MOTHER'S MAIDEN NAME Cecilia Hurlock				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 214-03-6118		17. INFORMANT Hospital Records,		Address Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infiltrating sarcoma of bladder wall DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 7 months ?								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan. 20, 19 58 , to June 4, 19 58 , that I last saw the deceased alive on June 4, 19 58 , and that death occurred at 6:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital								
ACTUAL SIGNATURE <i>G. Kosmahl</i> M.D.								
DATE SIGNED 6/4/58								
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.		M.D. Deer's Head State Hospital						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 9 '58		
						24b. REGISTRAR'S SIGNATURE <i>A. L. Leach</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

CERTIFICATE OF DEATH

DECEASED

05/03/2021

NAME OF DECEASED: MARY ANN HARRIS

ADDRESS: 101 E. BELMONT ST., BALTIMORE, MD 21202

CITY: BALTIMORE COUNTY

STATE: MARYLAND

ZIP CODE: 21202

PHONE NUMBER: (410) 333-1234

DATE OF DEATH: 05/03/2021

TIME OF DEATH: 10:00 AM

CAUSE OF DEATH: HEART DISEASE

METHOD OF DEATH: NATURAL

PLACE OF DEATH: HOME

NAME OF DOCTOR: DR. JAMES SMITH

ADDRESS OF DOCTOR: 123 W. BELMONT ST., BALTIMORE, MD 21202

PHONE NUMBER OF DOCTOR: (410) 333-1234

NAME OF FUNERAL HOME: MARY ANN'S FLOWERS

ADDRESS OF FUNERAL HOME: 101 E. BELMONT ST., BALTIMORE, MD 21202

PHONE NUMBER OF FUNERAL HOME: (410) 333-1234

NAME OF ATTENDING PHYSICIAN: DR. JAMES SMITH

ADDRESS OF ATTENDING PHYSICIAN: 123 W. BELMONT ST., BALTIMORE, MD 21202

PHONE NUMBER OF ATTENDING PHYSICIAN: (410) 333-1234

NAME OF AUTOPHYSICIAN: DR. JAMES SMITH

ADDRESS OF AUTOPHYSICIAN: 123 W. BELMONT ST., BALTIMORE, MD 21202

PHONE NUMBER OF AUTOPHYSICIAN: (410) 333-1234

NAME OF ATTENDING NURSE: NURSE JOAN SMITH

ADDRESS OF ATTENDING NURSE: 123 W. BELMONT ST., BALTIMORE, MD 21202

PHONE NUMBER OF ATTENDING NURSE: (410) 333-1234

ELAINE SMITH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07377

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

7423

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
		Reg. Dist. No.										
M 00		1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
I		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven		c. LENGTH OF STAY IN lb			b. COUNTY Wicomico					
V 22		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico River					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X White Haven					
A		3. NAME OF DECEASED (Type or print)			First Calvert	Middle Craig	Last Covington	4. DATE OF DEATH	Month 6	Day 11	Year 1958	
B		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/25/39	9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR 5 mos.	IF UNDER 24 HRS. 16 days	
C		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
D		13. FATHER'S NAME Calvert Covington			14. MOTHER'S MAIDEN NAME E. Elizabeth Robertson			Address Calvert Covington, White Haven, Md.				
E		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO. —			17. INFORMANT Calvert Covington, White Haven, Md.			INTERVAL BETWEEN ONSET AND DEATH Sudden	
F		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning			DUE TO 929.8							
G		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. —			(b) DUE TO —							
H		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
I		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wading in river and stepped off into deep water.							
J		20c. TIME OF INJURY Hour 3:15 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wicomico River, White Haven Wicomico Md.			(County) —		(State) —	
K		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
L		ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 6-13-58		
M		EXAMINER'S NAME (Type) Earl L. Royer, M.D.										
N		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/58		22c. NAME OF CEMETERY OR CREMATORIAL Grace Gem.		22d. LOCATION (City, town, or county) Mount Vernon Md.		(State) —		
O		23. FUNERAL DIRECTOR'S SIGNATURE Cornelius J. Messick, Burrow, Md.		ADDRESS —		24a. REC'D BY REGISTRAR JUN 17 1958		24b. REGISTRAR'S SIGNATURE W. E. Deutch				
P												
Q												
R												
S												
T												
U												
V												
W												
X												
Y												
Z												

WILSON COUNTY DEPARTMENT OF HEALTH - DENTAL
MEDICAL EXAMINERS CERTIFICATE OF DEATH

1000

RECEIVED

STATE OF

TEXAS

T

- I certify that the above information is true and correct.
 I declare under penalty of perjury that the information contained in this certificate is true and correct.
 I declare under penalty of perjury that the deceased was not under my care or treatment at the time of death.
 I declare under penalty of perjury that the deceased was not under the influence of any controlled substance at the time of death.
 I declare under penalty of perjury that the deceased was not under the influence of any illegal drug at the time of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7378

CERTIFICATE OF DEATH

07378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARSONSBURG</i>		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pennsylva General Hospital.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Baby Boy</i>	Middle <i>Daisey</i>	Lost	4. DATE OF DEATH	Month <i>JUNE</i>	Day <i>24</i>	Year <i>1958</i>				
5. SEX <i>Male</i>	6. COLOR OR ANCE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>JUNE 23 1958</i>	9. AGE (In years last birthday) yrs. Months <i>10 49</i>	IF UNDER 1 YEAR Months <i>10</i>	IF UNDER 24 HRS. Days <i>49</i>	Hours <i>Min.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>MANFORD THOMAS Daisey</i>		14. MOTHER'S MAIDEN NAME <i>Agnes</i>		Address <i>Manford Daisey - Parsonburg-Md.</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Atelectasis</i> <i>Prematurity (Birth wt 1600 gms.)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 hours</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Medical Center</i>	20f. (City or town) <i>Salisbury</i>	(County) <i>Md.</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>6/23/58</i> to <i>6/24/58</i> , that I last saw the deceased alive on <i>6/24/58</i> , and that death occurred at <i>8:07 AM</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Alfred C. Kelli</i> PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <i>Salisbury, Maryland</i>		DATE SIGNED <i>6/24/58</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/25/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mechanics Cemetery</i>	22d. LOCATION (City, town, or county) <i>Millsboro - Del.</i>	(State) <i>Del.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ronald James - Millsboro - Del.</i>	ADDRESS <i>2082325 XV2</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 30 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Aw. French</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

HANNAH

DECEASED

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

CITY

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. HANNAH	60	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1010 E. 12TH ST.	APT. 202	PHOENIX	ARIZ.
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. R. L. COOPER 1010 E. 12TH ST.	W. C. COOPER 1010 E. 12TH ST.		
NAME OF PERSON FILING CERTIFICATE	RELATIONSHIP TO DECEASED		
JOHN COOPER	SPOUSE		
ADDRESS OF PERSON FILING CERTIFICATE	STREET		
1010 E. 12TH ST.	APT. 202		
NAME OF PERSON SIGNING CERTIFICATE	STREET		
JOHN COOPER	1010 E. 12TH ST.		
DATE OF DEATH	TIME OF DEATH		
NOVEMBER 10, 1950	10:00 A.M.		
TIME OF ISSUANCE	STREET		
NOVEMBER 10, 1950	1010 E. 12TH ST.		
NAME OF PERSON ISSUING CERTIFICATE	STREET		
JOHN COOPER	1010 E. 12TH ST.		
PHONE NUMBER	STREET		
123456	1010 E. 12TH ST.		

07380

7380

CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN lb <u>12 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		d. STREET ADDRESS <u>208 SEVENTH ST</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Pocomoke City</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARENCE</u>		First <u>W.</u>	Middle <u>.</u>	Lost <u>DRYDEN</u>	4. DATE OF DEATH <u>JUNE 18 1958</u>	Month <u>JUNE</u>	Day <u>18</u>	Year <u>1958</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>SEPT. 19 1898</u>	9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>—</u>	IF UNDER 24 HRS. Days <u>—</u>	Hours <u>—</u>	Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSHUA D. DRYDEN</u>		14. MOTHER'S MAIDEN NAME <u>VANDELIA ANDREWS</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-01-9110</u>		17. INFORMANT Address <u>MRS CATHERINE S. DRYDEN, Pocomoke, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150 X</u>		DUE TO <u>Post caputitive Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <u>Separation of surface line</u>							
(c) <u>ca of edema</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u>		(County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>6-17 1958</u> to <u>6-18 1958</u> , that I last saw the deceased alive on <u>6-18 1958</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u>								DATE SIGNED <u>6-19-58</u>	
ACTUAL SIGNATURE <u>H. H. D. Dryden</u>		M.D.							
PHYSICIAN'S NAME (Type) <u>—</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-20-58</u>		22c. NAME OF CEMETERY OR Crematory <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) <u>Pocomoke City, Maryland</u>		(State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry B. Watson</u>		ADDRESS <u>Pocomoke City, MD.</u>		24a. REC'D. BY REGISTRAR <u>June 23 1958</u>		24b. REGISTRAR'S SIGNATURE <u>John Smith</u>			

CERTIFICATE OF DEATH

L-33

Date of Birth

Place of Birth

Name of Hospital

Name of Doctor

Name of Mortician

Name of Cemetery

Name of Coroner

Name of Sheriff

Name of Clerk

Name of Sheriff

Signature

Signature

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7381

CERTIFICATE OF DEATH

07381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. STREET ADDRESS 516 E. Isabella St		d. DATE OF DEATH JUNE 5th 1958	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle WINFIELD	Last DUNN
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1917
9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - Employee of Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Bivalve, Maryland	
10c. BIRTHPLACE (State or foreign country) Bivalve, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel L. Dunn		14. MOTHER'S MAIDEN NAME Grace L. Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Pauline A. Dunn (Wife) 516 E. Isabella St Salisbury, Maryland	
17. INFORMANT 500 X		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary & Bronchitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. Auto Dilatation of RT atrium & Ventric DUE TO (b) Cardio Hypertrophy - Atherosclerotic heart Disease. DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21 1958 to 6/6 1958 , that I last saw the deceased alive on 6/6 1958 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Andrew C. Mitchell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Jun. 8, 1958		22b. DATE THEREOF Parsons Cemetery	
22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7424

CERTIFICATE OF DEATH

07382

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Salisbury		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Daisey Lee Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Salisbury	
f. STREET ADDRESS R.D.# 5		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ELLEN Last ELSEY		4. DATE OF DEATH JUNE 8 th Year 19 58	
5. SEX Female COLOR OR RACE White WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 7. B. DATE OF BIRTH Dec. 2, 1872	
8. AGE (In years last birthday) 85 yrs.		9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 8 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Portsville, Delaware	
11. BIRTHPLACE (State or foreign country) Portsville, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lewis Cass Elzey		14. MOTHER'S MAIDEN NAME Emily Pollitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. William P. Elzey (Half-Brother) Address Ave. Baltimore 17, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO <i>Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 19 <i>58</i> , to <i>June 15</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/7</i> , 19 <i>58</i> , and that death occurred at <i>4:45</i> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. R. Gramse</i> ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>June 9 1958</i>			
PHYSICIAN'S NAME (Type) Dr. Fred Gramse		S. Division St. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF Jun. 11/58	
22c. NAME OF CEMETERY OR CREMATORIUM Odd Fellow Cemetery		22d. LOCATION (City, town, or county) Laurel, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE <i>Reinhardt</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH - DEATH

CERTIFICATE OF DEATH

DEATH DATE	REGISTRATION NO.	NAME
1999-01-01	1000123456	JOHN D. SMITH
ADDRESS		
1234 FAIRFIELD DR. JACKSONVILLE, IL 62650		
CITY, STATE, ZIP		
JACKSONVILLE, IL 62650		
PHONE NUMBER		
(319) 243-1234		
RELATIONSHIP TO DECEASED		
HUSBAND		
MATERIAL TESTED		
BLOOD		
TESTS CONDUCTED		
HIV		
Hepatitis C		
Hepatitis B		
Syphilis		
Tuberculosis		
Other		
TEST RESULTS		
HIV: NEGATIVE		
Hepatitis C: NEGATIVE		
Hepatitis B: NEGATIVE		
Syphilis: NEGATIVE		
Tuberculosis: NEGATIVE		
Other:		
NOTES		
None		
SIGNATURE		
DR. JAMES M. SMITH, MD		
FAX: (319) 243-1234		
PHONE: (319) 243-1234		
EMAIL: jsmith@jacksonville.org		
ADDRESS: 1234 FAIRFIELD DR., JACKSONVILLE, IL 62650		
LICENSE NUMBER: 1234567890		
EXPIRATION DATE: 12/31/2010		
SIGNATURE		
DR. JAMES M. SMITH, MD		
FAX: (319) 243-1234		
PHONE: (319) 243-1234		
EMAIL: jsmith@jacksonville.org		
ADDRESS: 1234 FAIRFIELD DR., JACKSONVILLE, IL 62650		
LICENSE NUMBER: 1234567890		
EXPIRATION DATE: 12/31/2010		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07383				
7382 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>					c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>					b. COUNTY <i>Worcester</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>					d. STREET ADDRESS <i>1312 Princes Anne Lane.</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		Mark	First	Steven	Middle	Farr	Lost	4. DATE OF DEATH <i>Farr</i>	Month <i>June</i>	Day <i>21</i>	Year <i>1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 30. 1958</i>		9. AGE (In years lost birthday) yrs. <i>2</i>		10. IF UNDER 1 YEAR Months <i>2</i>		11. IF UNDER 24 HRS. Hours <i>21</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY <i>P.G. Hospst. Salisbury,</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland, U.S.A.</i>				
13. FATHER'S NAME <i>Sterling J. Farr.</i>					14. MOTHER'S MAIDEN NAME <i>Jerry Morrow.</i>					12. CITIZEN OF WHAT COUNTRY?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Mr. Sterling J. Farr, Father, 1312 Princes Anne Lane. Pocomoke, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>773.5</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral Edema - marked.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypoxic Cerebral damage in Perinatal Period</i> (c) <i>Brematurity (Birth wt 2 lbs - 3 oz.)</i>										DUE TO <i>82 Days</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month <i>19</i>	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Salisbury</i>		(County) <i>Wicomico</i>		(State) <i>Maryland</i>	
21. I certify that I attended the deceased from <i>4/30</i> , 1958, to <i>6/1</i> , 1958, that I last saw the deceased alive on <i>6/21</i> , 1958, and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <i>Medical Center, Salisbury, Maryland</i>				
ACTUAL SIGNATURE <i>Alfred C. Kolls, M.D.</i>					DATE SIGNED <i>6/21/58</i>									
PHYSICIAN'S NAME (Type) <i>V. Kolls</i>														
22a. BURIAL CREMATION, REMOVAL OR BURIAL <i>Burial</i>					22b. DATE THEREOF <i>June 25. 58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Elmwood Cemetery.</i>			22d. LOCATION (City, town, or county) <i>Birmingham, Ala.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Holloway & Company, Salisbury, Maryland</i>					ADDRESS <i>Holloway & Company, Salisbury, Maryland</i>					24a. REC'D. BY REGISTRAR <i>JUN 24 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Q. K. Lewis</i>		

but will now be bettered

2. *Stenocercus* sp. nov. (holotype) *Stenocercus*
(*Echis* sp. 1943) *Stenocercus*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 07385		
7425 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		P.O. Box 53		20X-2				
Salisbury		5 yrs. 10 mo.		Bellevue								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Deer's Head State Hospital		d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)		First Sarah	Middle Elizabeth	Last Gibson	4. DATE OF DEATH	Month June	Day 19,	Year 1958				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	1883	9. AGE (In years last birthday)	76 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
Female		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 10, 1887		Yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Laborer			--		--		USA					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
*					--							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.			16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
--			217-09-3273A		Deer's Head Hospital, Salisbury, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										10 days		
443X Recurrent cerebral hemorrhage												
DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.										Years		
(b) Hypertensive cardiovascular disease												
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from August 18, 1952, to June 19, 1958, that I last saw the deceased alive on June 19, 1958, and that death occurred at 7:15 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE		Dr V Juerman		M.D.		Deer's Head State Hospital		DATE SIGNED				
PHYSICIAN'S NAME (Type)		V. Juerman, M. D.				Salisbury, Maryland		6/20/58				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)				
Burial		6/25/58		Richards Cem		Boston, Md						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
James B. Lovell		Boston, Md.		JUN 26 '58		W. Finch						

07386.

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		d. STREET ADDRESS <u>500 Young St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Timothy</u>		First	Middle	Lost	4. DATE OF DEATH <u>Billett</u>	Month	Year
S. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1896</u>	1916	9. AGE (In years last birthday) yrs. <u>42</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Fosque</u>		Address <u>Ethel Mason - Accomac, Va.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO		Carcinoma of the lung					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-7-</u> , 19 <u>58</u> , to <u>6-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>58</u> , and that death occurred at <u>11:08</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene J. Lemberg</u>		ADDRESS (Street, city or town, state) <u>Accomac, VA.</u>					
PHYSICIAN'S NAME (Type)		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-22-58</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Accomac</u>		22d. LOCATION (City, town, or county) (State) <u>Accomac VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whiston - New Church, Va.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Smith</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tent permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - CALIFORNIA

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JULIA M. HALL

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JULIA M. HALL

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CITY OF LOS ANGELES DEPT OF PUBLIC WORKS, CALIFORNIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Film G230 6-18-58 et

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7384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X MARDELA.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS 1 RURAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First IDA	Middle G	Lost	4. DATE OF DEATH	Month June	Day 2	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-12-1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME BENJAMIN GRAVENOR		14. MOTHER'S MAIDEN NAME ELIZABETH ROUSSEAU		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIE ENGLISH - MARDELA MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Unknown								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jessup		(County) Calvert	(State) MD		
21. I certify that I attended the deceased from 5-15 , 19 58 , to June 2 , 19 58 , that I last saw the deceased alive on 6-2 , 19 58 , and that death occurred at P. O. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jessup, MD DATE SIGNED 6-2-58								
ACTUAL SIGNATURE Willie B. Ellis Jr.	M.D.							
PHYSICIAN'S NAME (Type) Willie B. Ellis Jr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-4-58	22c. NAME OF CEMETERY OR CREMATORIY MARDELA	22d. LOCATION (City, town, or county) MARDELA - MD		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marrel, Shadytown Rd.	ADDRESS Shadytown Rd.	24a. REC'D BY REGISTRAR JUN 6 '58	24b. REGISTRAR'S SIGNATURE Outasil					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7385 CERTIFICATE OF DEATH

07388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mardela					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital				d. STREET ADDRESS R.D.# (Athol Road)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle MILTON	Last HARRISON	4. DATE OF DEATH	Month JUNE	Day 8	Year th 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jun. 28, 1893	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper-Road Construction		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME George W. Harrison		14. MOTHER'S MAIDEN NAME Carrie M. Thornton							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 123-45-6789		17. INFORMANT Mrs. Etta G. Harrison (wife) R.D.#(Athol Rd Mardela, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Myocardial Insufficiency		INTERVAL BETWEEN ONSET AND DEATH					
		Cor pulmonale, chronic							
		Chronic Bronchitis; Bronchiectasis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Probable pulmonary tuberculosis							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 12:20 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE David Gilmore		M.D.		ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED June 9 1958			
PHYSICIAN'S NAME (Type) Dr. David Gilmore		M.D.		Medical Center-Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 11/58		22c. NAME OF CEMETERY OR CREMATORIUM Mardela Cemetery		22d. LOCATION (City, town, or county) Mardela, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 10 '58		24b. REGISTRAR'S SIGNATURE DeLoach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

period of world history up to
and including the present time
is considered primarily as a period
of religious development and
redevelopment.

DR. judeus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07389

7386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		d. STREET ADDRESS 23X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William J. Hastings		First	Middle	Lost	4. DATE OF DEATH June 11 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1879	9. AGE (In years (put birthday) 79 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) BERLIN MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME WILLIAM J. HASTINGS JR		14. MOTHER'S MAIDEN NAME MARTHA ANNIE DAVIS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. NORMAN HASTINGS Ocean City Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for Part I(b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		DUE TO <i>Cardio vascular renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. {		(b) DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 28, 1958 to 6-11 1958 , that I last saw the deceased alive on 6-10 1958 and that death occurred at 5 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>George A. Insley</i>		ADDRESS (Street, city or town, state) Salisbury Md.		DATE SIGNED 6-11-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN CEMETERY		22d. LOCATION (City, town, or county) BERLIN MD.		
23. FUNERAL DIRECTOR'S SIGNATURE George A. Burbridge Berlin Md.		ADDRESS George A. Burbridge Berlin Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE Deborah		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 F17w0230 6-22-58 et
CERTIFICATE OF DEATH

07390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wisconsin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wisconsin</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverview</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution)		e. STREET ADDRESS <i>Jesterville</i>	
3. NAME OF DECEASED (Type or print) <i>George P. Heath</i>		4. DATE OF DEATH <i>June 9 1958</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/2/67</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>Body Builder</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>John Thomas Heath</i>	
14. MOTHER'S MAIDEN NAME <i>Susan Priscilla White</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>- - -</i>		17. INFORMANT <i>Miss Naomi Heath</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Bronchitis pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Disease</i> DUE TO <i>Arteriosclerotic Heart Disease</i> (c) <i>24 hours</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>491X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Jesterville</i> (County) <i>Wicomico Co.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>July 1958</i> to <i>September 1958</i> that I last saw the deceased alive on <i>June 1958</i> , and that death occurred at <i>Jesterville</i> A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Richard H. Saunders</i> M.D.		ADDRESS (Street, city, or town, state) <i>Nanticoke, Maryland</i> DATE SIGNED <i>6/9/58</i>	
PHYSICIAN'S NAME (Type) <i>Richard H. Saunders</i>		22a. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>Jesterville Cem.</i>	
22b. DATE THEREOF REMOVAL (Specify) <i>6/11/58</i>		22c. LOCATION (City, town, or county) (State) <i>Jesterville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cornelia J. Mead, Bristow, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 17 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arch. E. L. E.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. File pages 1 and 2 with the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07391

Reg. Dist. No.

7427

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Delmar				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 3			d. STREET ADDRESS R.D.# 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ROLAND	Middle DANIEL	Last HILL	4. DATE OF DEATH	Month JUNE	Day 6 th	Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1900	9. AGE (in years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R.D.# Laurel Delaware		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Elijah Emory Hill				14. MOTHER'S MAIDEN NAME Elizabeth Plummer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Bolen (Sister) R.D.# 3 Delmar Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Ceremonies Decline Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) DUE TO								
INTERVAL BETWEEN ONSET AND DEATH Shudder								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED June 7 1958			
EXAMINER'S NAME (Type) Dr. Earl L. Royer								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 9, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 10 '58			24b. REGISTRAR'S SIGNATURE <i>As requested</i>	
VS. A15ME BM 2/57								

WISCONSIN STATE BOARD OF HIGHER EDUCATION
STATE COLLEGE OF WISCONSIN

STATE
COLLEGE

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07392

Reg. Dist. No.

1
7387
1. PLACE OF DEATH

a. COUNTY Wicomico MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland b. COUNTY Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

12 Salisbury

d. LENGTH OF STAY IN 1b

D.O.A. Pen Gen. Hospital

d. STREET ADDRESS

838 Brown St

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First WILLIAM

Middle WANNER

Last HILL

4. DATE
OF
DEATH

JUNE

9 th 19 58

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

CHILD

DIVORCED

8. DATE OF BIRTH

Nov. 5, 1955

9. AGE (In years
last birthday)

2 yrs.

IF UNDER 1 YEAR

Months 2

IF UNDER 24 HRS.

Days 24

Hours 0

Min. 0

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

William W. Hill Sr

14. MOTHER'S MAIDEN NAME

Mabel M. Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. William W. Hill (Father) 838 Brown St
Salisbury, Maryland

Address
INTERVAL BETWEEN
ONSET AND DEATH
SUDDEN

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

FRACTURED SKULL

813X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES NO

0
22
2
MATERIAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Child fell from bicycle under truck

20c. TIME OF INJURY Month, Day, Year
Hour

2:30 p.m. 6 9 1958

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office, bldg., etc.)

20f. (City or town)
(County)
(State)

Brown St
Salisbury Wicomico Md

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Dr. Earl L. Royer

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

June 10 1958

220. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

226. DATE THEREOF

Jun. 12, 1958

22c. NAME OF CEMETERY OR CREMATORIUM

Wicomico Memorial Park

22d. LOCATION (City, town, or county)

(State)

Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

HOLLOWAY & COMPANY

ADDRESS

SALISBURY MARYLAND

24a. REC'D BY REGISTRAR

JUN 13 '58

24b. REGISTRAR'S SIGNATURE

Earl L. Royer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
6M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7388 CERTIFICATE OF DEATH

07393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb		b. COUNTY SOMERSET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General HOSPITAL.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bessie		First Bessie	Middle 	Last HOFFMAN	4. DATE OF DEATH JUNE 4, 1958		
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 17, 1900		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARTIN, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST MICHAEL			14. MOTHER'S MAIDEN NAME ETTA BURGESS			Address MRS. THOMAS PARKS - FAIRMOUNT, MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT INTERVAL BETWEEN ONSET AND DEATH approx. 2 yrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260.1				Myocardial Insufficiency		Coronary Artery Heart Disease " 3 yrs	
				Coronary Atherosclerosis		Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus; Hepato-renal Failure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month June Day 4 Year 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Md.		20f. (City or town) (County) Salisbury (State) Md.	
21. I certify that I attended the deceased from June 4, 1958 , to 15 , 19 58 , that I last saw the deceased alive on June 4, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 6/4/58							
ACTUAL SIGNATURE David J. Gilmore		PHYSICIAN'S NAME (Type) DAVID J. GILMORE, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 7, 1958		22c. NAME OF CEMETERY OR CREMATORIAL FAIRMOUNT CEMETERY		22d. LOCATION (City, town, or county) FAIRMOUNT, MD. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS - CRISPFIELD, MD.				ADDRESS 		24a. REC'D BY REGISTRAR DATE JUN 6 '58	
						24b. REGISTRAR'S SIGNATURE DeLoach	

21 STATE OF HAWAII - CALIFORNIA

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07394

CERTIFICATE OF DEATH

Reg. Dist. No.

7389

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Selbyburg</i>		c. LENGTH OF STAY IN lb <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		d. STREET ADDRESS <i>413 Oxford st.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>231122</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Eben</i>	Middle <i></i>	Last <i>Holden</i>	4. DATE OF DEATH	Month <i>June</i>	Day <i>3-</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 4 1958</i>	9. AGE (In years lost birthday) yrs. <i>37</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>1</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Holden</i>		14. MOTHER'S MAIDEN NAME <i>Etta Robinson</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Holden</i>		Address <i>413 Oxford St Selbyburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.0</i>		DUE TO <i>Aspiration, acute, with focal</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		(b) DUE TO <i>Atelectasis and anoxemia</i>					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congenital bilateral brachial plexus, clavicular absence of clavicle +</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Myoplasia adhesiva</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) (County) (State) <i>6/21/58</i>	
21. I certify that I attended the deceased from <i>6/21/58</i> to <i>6/3/58</i> , 1958, that I last saw the deceased alive on <i>6/21/58</i> , 1958, and that death occurred at <i>8:30</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.H. Gandy, M.D.</i>				ADDRESS (Street, city or town, state) <i>207 Linden Ave.</i>		DATE SIGNED <i>6/3/58</i>	
PHYSICIAN'S NAME (Type) <i>Edgar Wharton - New Church, Va</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 8, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cottage Grove, Cem.</i>		22d. LOCATION (City, town, or county) <i>Westover, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New Church, Va</i>		ADDRESS <i>4000261XV5</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 9 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. Resnick</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07395

7428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 253 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle William	Last Holland	4. DATE OF DEATH June 26 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1886	9. AGE (In years lost birthday) yrs. 72	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ira Frank Holland			14. MOTHER'S MAIDEN NAME Duncan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk			16. SOCIAL SECURITY NO. Unk		
17. INFORMANT Hospital Records,			Address Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0			INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis, general			Years		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Residual Right Hemiplegia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15, 1957 , to June 26, 1958 , that I last saw the deceased alive on June 26, 1958 , and that death occurred at 10:05 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland			
ACTUAL SIGNATURE <i>G. Kosmahl</i>		DATE SIGNED 6/26/58			
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.		Deer's Head State Hospital 6/26/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-58		22c. NAME OF CEMETERY OR CREMATORIUM Brittingham Cemetery	
22d. LOCATION (City, town, or county) Rural New Church, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>		ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR JUN 30 1958	
				24b. REGISTRAR'S SIGNATURE <i>W. E. Gedrich</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18-21 Film 231 7-7-58 am 07396

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlantic 83X-3	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gary Frederick Hudson		First	Middle
4. DATE OF DEATH 6-18-1958		Month	Doy Year
5. SEX M Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 15, 1953		9. AGE (In years last birthday) 5 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Nassawady Va	
12. CITIZEN OF WHAT COUNTRY? M. S. A.			
13. FATHER'S NAME Frederick Hudson		14. MOTHER'S MAIDEN NAME Hedalah Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Leonard Taylor		Address Horsey Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-arachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and hurt head in tussle with another child.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. P. M. p. m. 6-17-58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) Atlantic (County) Accomack (State) Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 6-20-58	
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/58	
22c. NAME OF CEMETERY OR CREMATORIAL Downings		22d. LOCATION (City, town, or county) Oak Hall Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Richard Johnson</i>		ADDRESS Parkley, Va.	
24a. REC'D BY REGISTRAR JUN 25 '58		24b. REGISTRAR'S SIGNATURE <i>Richard</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7391

CERTIFICATE OF DEATH

07397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE N Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 56 W. Kearsarge Circle	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle FRED	Last HULL
4. DATE OF DEATH	Month June	Day 12	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Baby	8. DATE OF BIRTH Jun. 10, 1958
9. AGE (In years lost birthday) yrs. 0	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 2	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Chincoteague Air Station Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fred Albron Hull		14. MOTHER'S MAIDEN NAME Helen Lamp Cheek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Lt. Fred A. Hull (Father) 56 W. Kearsarge Circle - Chincoteague, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Torsion of small bowel (Post mortem) 1 day (b) Dysphagia DUE TO Diaphragmatic Hernia with dislocation of abdominal viscera into chest 1/2 day (c) Emphysema			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Emphysema of lungs and kidneys; atelectasis of lungs	
20c. TIME OF INJURY Hour o. m. p. m.	Month June	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 19	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.
20f. (City or town) June 10, 1958	(County) June 12, 1958	(State) June 13, 1958	
21. I certify that I attended the deceased from June 10, 1958 to June 12, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 905A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dr. Robert W. Saunderson Jr. Camden Ave., Salisbury, Maryland			
DATE SIGNED June 13, 1958			
ACTUAL SIGNATURE R. W. Saunderson Jr. M.D.		PHYSICIAN'S NAME (Type) Dr. Robert W. Saunderson Jr. Camden Ave., Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 14, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Cabarrus Memorial Cen.	22d. LOCATION (City, town, or county) Concord, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR JUN 16 '58		24b. REGISTRAR'S SIGNATURE Robert W. Saunderson Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7392

CERTIFICATE OF DEATH

Reg. Dist. No.

07398

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>31 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>Banister Ave</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pennsylva General Hospital</i>				d. STREET ADDRESS <i>Banister Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Helen</i>		First	Middle	Lost	4. DATE OF DEATH <i>Jamar-T June 22 1958</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>June 18 1897</i>	8. AGE (in years lost birthday) <i>61 yrs.</i>	9. IF UNDER 1 YEAR Months <i>0</i>	10. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>College</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Thomas M. Jamar</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Wilhelm</i>				Address <i>Grace S Smith 606 Hollen Rd</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>215-38-0084</i>		17. INFORMANT <i>Grace S Smith</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>527.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Edouf</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from _____, 19_____, and that death occurred at _____, 19_____, and that death occurred at <i>6/18/58</i> , to <i>6/22/58</i> , that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>10:25 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Salisbury, Md</i>		DATE SIGNED <i>6-23-58</i>	
ACTUAL SIGNATURE <i>William S. Jenkins</i>		PHYSICIAN'S NAME (Type) <i>M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-15-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>GREENMOUNT</i>	22d. LOCATION (City, town, or county) <i>BALTO.</i>	(State) <i>MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.W. JENKINS & SONS CO.</i>		ADDRESS <i>4905 YORK RD.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>West couch</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director.
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7393

CERTIFICATE OF DEATH

07399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>SOMERSET</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CRISFIELD</i>		d. STREET ADDRESS <i>BROADWAY</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Edith</i>	Middle —	Lost —	4. DATE OF DEATH <i>Jones</i>	Month <i>June</i>	Day <i>5</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 19, 1910</i>	9. AGE (In years last birthday) <i>47 yrs.</i>	IF UNDER 1 YEAR Months <i>—</i>	IF UNDER 24 HRS. Days <i>—</i>	Hours <i>—</i>	Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEAFOOD WORKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CRAB & OYSTER</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>EOWIN JONES</i>		14. MOTHER'S MAIDEN NAME <i>MAGGIE HARRIS</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>231-12-3950</i>		17. INFORMANT <i>VIRGINIA STERLING, CRISFIELD, MO.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150x</i>		DUE TO <i>Carcinoma of esophagus</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>—</i>		DATE SIGNED	
ACTUAL SIGNATURE <i>Eugene J. Linberg</i>									
PHYSICIAN'S NAME (Type) <i>EUGENE J. LINBERG</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-9-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>LAWSONIA CEMETERY</i>		22d. LOCATION (City, town, or county) <i>CRISFIELD, MO.</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. HARVEY BRAUSHAW, MARYLAND</i>		ADDRESS <i>CRISFIELD, MARYLAND</i>		24a. REC'D BY REGISTRAR <i>JUN 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albertouch</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07400

Reg. Dist. No.

7394

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Salisbury (Rural)

d. STREET ADDRESS

Mt. Hermon Rd.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)

First

LILLIE

Middle

DALE

Last

KELLEY

4. DATE
OF
DEATH

Month

Day Year

June 28 1958

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

August 31, 1887

9. AGE (In years
at birthday)
yrs.

9 27

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Willards, Maryland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

James K. Patey

14. MOTHER'S MAIDEN NAME

Sarah Margaret

Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

V. INFORMANT

Mrs. Harry V. Jones (Daughter) Address
Salisbury, Maryland

17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

Acute Pulmonary Edema

INTERVAL BETWEEN
ONSET AND DEATH

1 hour

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

DUE TO

(b)

Hyperkinetic Heart Disease

Year

DUE TO

(c)

Atherosclerotic cardiovascular disease

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased
alive on _____, and that death occurred at _____, and that death occurred at _____, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Dr. O.J. Burton

M.D.

Maryland Ave. Salisbury, Md Jun. 28, 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Jun. 30, 1958

22c. NAME OF CEMETERY OR CREMATORI

Parsons Cemetery

22d. LOCATION (City, town, or county)

(State)

Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

HOLLOWAY & COMPANY

SALISBURY, MARYLAND

24a. REC'D BY REGISTRAR
DATE JUL 1 '5824b. REGISTRAR'S SIGNATURE
G. L. Beouch

AMERICAN STATE DEPARTMENT - AVAILABILITY OF INFORMATION ACT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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VS A15 (4)
 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7429

CERTIFICATE OF DEATH

Reg. Dist. No.

07401

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle John	Last Kohn	4. DATE OF DEATH	Month June	Day 19	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Jan. 3, 1887	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME William Kohn				14. MOTHER'S MAIDEN NAME Sophia Losand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Helen Watson, Mardela Springs, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colitis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Obstruction DUE TO (c) Obstruction DUE TO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) No							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Ingestion							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1958 , to June 19, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mardela Springs DATE SIGNED July 1, 1958							
ACTUAL SIGNATURE Fred C. Dunn		PHYSICIAN'S NAME (Type) FRED C. DUNN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-58		22c. NAME OF CEMETERY OR CREMATORIUM Mardela		22d. LOCATION (City, town, or county) (State) Mardela Springs	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Gammill, Shaylong		ADDRESS		24a. REC'D BY REGISTRAR JUN 23 1958		24b. REGISTRAR'S SIGNATURE Att. Deacon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

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VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7395

CERTIFICATE OF DEATH

07402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lovella		First MARSH	Middle Last
4. DATE OF DEATH June 21, 1958		Month Year	Day Year
5. SEX Female		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH APRIL 26, 1894		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) TYLERTON, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES T. EVANS	
14. MOTHER'S MAIDEN NAME ANNA BRADSHAW		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT ERVIN C. MARSH - 530 WASHINGTON ST. - MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 14 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1958 , to June 21, 1958 , that I last saw the deceased alive on June 21, 1958 , and that death occurred at 10:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 711 Camden DATE SIGNED 6/21/58			
ACTUAL SIGNATURE Alberta Mattax		M.D.	
PHYSICIAN'S NAME (Type) ALBERTA MATTAX, M.D.		711 CAMDEN ST. - SALISBURY, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 23, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM SUNNYRIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) CRISFIELD, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS - CRISFIELD, MD.		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. Bradshaw	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07403

7396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 905 Register St.,		d. STREET ADDRESS 905 Register St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First EMRA	Middle LEE	Last MARVEL	4. DATE OF DEATH	Month 6	Day 22	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1884	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Marvel				14. MOTHER'S MAIDEN NAME Clara Beach				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1903-06		17. INFORMANT Mrs. Emma M. Marvel, Same		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Carcinoma (Bronchogenic) of lung. 4 mos INTERVAL BETWEEN ONSET AND DEATH 21 hr								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/28 , 1958, to 4/22 , 1958, that I last saw the deceased alive on 3/26 , 1958, and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Parsons Cemetery, Salisbury, Maryland DATE SIGNED 6/24/58								
ACTUAL SIGNATURE <i>Rufus S. Gardner Jr.</i>		PHYSICIAN'S NAME (Type) Rufus S. GARDNER, JR. Medical Center						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman T. Baker		24a. REC'D BY REGISTRAR DATE JUN 25 1958		24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7397 CERTIFICATE OF DEATH

07404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 235 Middle Blvd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nellie		First	Middle	Last	4. DATE OF DEATH June 28	Month	Day	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1875		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME W. F. Massey				14. MOTHER'S MAIDEN NAME Melinda		Phoebus		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT F.R. Stansel, 33 Elm St. Mass.		Address W. Andover		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure & Atrial Fibrillation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hypertension & Heart Disease						INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO 7 Hypertension & heart disease								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown, Maryland		(County) Wicomico (State) Maryland
21. I certify that I attended the deceased from January 15, 1958 to June 28, 1958 , that I last saw the deceased alive on June 27, 1958 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 226 N. Division St., Salisbury, Md.								
DATE SIGNED								
ACTUAL SIGNATURE Dr. Carrie I. Hearn								
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury		ADDRESS Norman T. Baker		24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE Alt. Search		

87 2009R145-0011ACM 80 1000198623 STATE OF ALABAMA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7430

CERTIFICATE OF DEATH

Reg. Dist. No.

07405

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		c. LENGTH OF STAY IN 1b X Eden	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2		e. STREET ADDRESS / R.D.# 2	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARITA MAE McDORMAN	First	Middle	Last
4. DATE OF DEATH JUNE 4th 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1913
9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR 1 Months	11. IF UNDER 24 HRS. 29 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		11. BIRTHPLACE (State or foreign country) Smyrna, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Albert F. Lewis		14. MOTHER'S MAIDEN NAME Nannie Wade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr John William McDorman (Husband) R.D.#2 Eden, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. J yes.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 1958 , to June 1958 , that I last saw the deceased alive on 6/4/58 , and that death occurred at Maryland Ave , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED Earl Beardsley	
ACTUAL SIGNATURE Earl Beardsley		M.D.	
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley		Maryland Ave Salisbury, Md Jun 6 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Mem. Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR JUN 10 1958		24b. REGISTRAR'S SIGNATURE Earl Beardsley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HT436 90 - 100-1150

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7398 CERTIFICATE OF DEATH

07406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Oklahoma</i>		b. COUNTY <i>Pennsauken</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 Day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Haven Beach</i>		d. STREET ADDRESS <i>517 South West 16 ave</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Simmie</i>	Middle <i>Lee</i>	Last <i>McINTOSH</i>	4. DATE OF DEATH <i>June 23, 1958</i>	Month <i>June</i>	Day <i>23</i>	Year <i>1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb 16-1907</i>	9. AGE (In years less birthday) <i>54 7 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W.S. Only Canvassing</i>		11. BIRTHPLACE (State or foreign country) <i>Idalia, Georgia</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Charlie Mcintosh</i>		14. MOTHER'S MAIDEN NAME <i>Mazie Dickles</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Sadie McIntosh 517 S.W. 16 ave</i>		Address <i>Pompano Beach, Florida</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>445X</i>		DUE TO <i>Cerebral Hemorrhage</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		DUE TO <i>Cerebral Atherosclerosis</i>						
(c) <i>Malignant Hypertension</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
<i>6/23 1958</i>		<i>6/23 1958</i>		<i>6/23 1958</i>		<i>Salisbury, Md. Wicomico, Md.</i>		
21. I certify that I attended the deceased from <i>6/23, 1958</i> to <i>6/23, 1958</i> that I last saw the deceased alive on <i>6/23, 1958</i> , and that death occurred at <i>6/23, 1958</i> , M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>David J. Silivone</i>		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>June 23, 1958</i>				
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 29/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Baptist Cemetery</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Dennis</i>		ADDRESS <i>Snow Hill, Md.</i>		24e. REC'D BY REGISTRAR <i>Webb couch</i>		24f. REGISTRAR'S SIGNATURE		
				DATE JUN 26 '58				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF EDUCATION - STATE OF CALIFORNIA

CERTIFICATE OF DEATH

Two if for one certificate
Folsom 9231 - 7/6/58 -
M.B.

John G. Johnson
and wife
inventor

John G. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7399

Items 8, 9, 11, 12, 13, 14 Film G230 6-17-58 et

07407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>SOMERSET</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>210 DAYS.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PRINCESS ANNE 19X-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>		d. STREET ADDRESS <i>R.B. 3</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>CARL</i>	Middle	Last <i>McINTYRE</i>	4. DATE OF DEATH <i>JUNE 1 1958</i>	Month <i>JUNE</i>	Day <i>1</i>	Year <i>1958</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>December 7, 1889</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James R. McIntyre</i>		14. MOTHER'S MAIDEN NAME <i>Georgiana Jones</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>447X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Vascular Disease</i> DUE TO (c) <i>cardiac</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>3 wks.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-1</i> , 19 <i>58</i> to <i>6-1</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-1</i> , 19 <i>58</i> , and that death occurred at <i>5:14 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Neuman Jr.</i> PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>6-1-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>6/3/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Andrews</i>	22d. LOCATION (City, town, or county) <i>Princess Anne, Md.</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Neuman Princess Anne Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 10 1958	24b. REGISTRAR'S SIGNATURE <i>Alt. eugen</i>				

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55.10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07408

7400 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY *Wicomico*
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN *Salisbury*

MD
MARYLANDLENGTH OF STAY
(in this place)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

J. S. Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE *Md*
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN *Salisbury*

COUNTY *Wicomico*STREET
ADDRESS

(If rural give location)

**3. NAME OF
DECEASED
(Type or Print)**

(First) *Merritt* (Middle) *Richard* (Last) *Merritt*.

4. DATE (Month) (Day) (Year)
OF DEATH *6 6 58*

5. SEX *m*6. COLOR OR
RACE *col*7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) *widow*8. DATE OF BIRTH *12-6-01*9. AGE last birthday *57*
yrs. *12*IF UNDER 1 YEAR
Months *0* Days *0* Hours *0* Min. *0*10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) *none*10b. KIND OF BUSINESS
OR INDUSTRY *none*11. BIRTHPLACE (State or foreign country) *VA*12. CITIZEN OF WHAT
COUNTRY?13. FATHER'S NAME *?*14. MOTHER'S MAIDEN NAME *?*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) *592x* (If Yes, give war or dates of service) *none*16. SOCIAL SECURITY NO. *none*17. INFORMANT & ADDRESS *Charles Slonely***I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**592x IMMEDIATE CAUSE *Chronic bronchitis*

(A)

ANTECEDENT CAUSE(S) DUE TO *Chronic bronchitis*
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO *Chronic bronchitis*
STATING UNDERLYING CAUSE LAST. (C)INTERVAL BETWEEN
ONSET AND DEATH*1 month***II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

2d. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from *July 1958*, to *1958*, that I last saw the deceased
alive on *July 1958*, and that death occurred at *Salisbury* M. from the causes and on the date stated above.
SIGNATURE *Merrill* ADDRESS (Street, city, town, state) *152 W. Main Salisbury, Md.* DATE SIGNED *1958*

23. BURIAL, CREMATION,
REMOVAL (SPECIFY) *Burial*DATE THEREOF *6-14-58* NAME OF CEMETERY OR CREMATORIAL *Houston Cem.* LOCATION (City, town, or county) *Salisbury* (State) *Md.*

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE *Ab. Smith* 25. FUNERAL DIRECTOR'S SIGNATURE *Booker McWeak* ADDRESSDATE *JUN 16 '58*

SI LEROMINAS-STASH TO THE UNITED STATES CHARTER

STATE TO STATE CHARTER

APPROVED AND CROWN APPROVED 1945

NAME OF CHARTER

CHARTER

AMERICAN
HEADS

NAME OF CHARTER

AMERICAN HEADS
CHARTER

CHARTERED BY AMERICAN HEAD CHARTER COMPANY LTD.

CHARTERED

TA 01

1
FOR STATE
HEALTH DEPT.

M

82
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designee, agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
740 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wiscomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wiscomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN lb LIFE TIME
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital	12 STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Donald	Middle Mills, Jr.	4. DATE OF DEATH Month 6- Doy 17- Year 1958
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5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9.20/56	9. AGE (In years lost birthday) 1 yrs.	IF UNDER 1 YEAR Months 8 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U S A
--	--	--	------------------------------------

13. FATHER'S NAME DONALD MILLS SR.	14. MOTHER'S MAIDEN NAME LAURA CHENAULT
------------------------------------	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	LAURA CHENAULT. SALISBURY, MD.		
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PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Edema of the brain	INTERVAL BETWEEN ONSET AND DEATH Sudden
---	--------------------	---

351X- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b) Cerebral palsy	20 months.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
---	--	--	--

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
---	--	--	--	--	--	--

ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
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EXAMINER'S NAME (Type) Earl L. Royer, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
--	---

6-18-58

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/18/58	22c. NAME OF CEMETERY OR CREMATORIAL HOUSE JACOB	22d. LOCATION (City, town, or county) CHANCE	(State) MARYLAND
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23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. James Jr.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 20 '58	24b. REGISTRAR'S SIGNATURE <i>Archibechuk</i>
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STATE OF CALIFORNIA
EXAMINER'S CERTIFICATE OF DETAIL

NOTARIAL
STATE OF CALIFORNIA

NOTARIAL
STATE OF CALIFORNIA

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STATE OF CALIFORNIA

T

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7402 CERTIFICATE OF DEATH

07410

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Salisbury				12 Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Pen. Gen. Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
First MILDRED		Middle MAE	Last MULFORD	108 E. Locust St.		Month JUNE	Day 3 rd	Year 19 58
3. NAME OF DECEASED (Type or print)								
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 21, 1905	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Hours 12	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Wingate, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
House Work								
13. FATHER'S NAME George H. Jones		14. MOTHER'S MAIDEN NAME Elnora Ewell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. C. Clifton Mulford (Husband) 108 E. Locust St. Salisbury, Maryland		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		metastatic carcinoma of lung.		INTERVAL BETWEEN ONSET AND DEATH 4 mos.		
17IX		(b) DUE TO carcinoma of cervix				2 yrs.		
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from Sept. 1958, to Oct. 1958, that I last saw the deceased alive on June 6, 1958, and that death occurred at 10:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Earl Beardsley</i> PHYSICIAN'S NAME (Type) Dr. Earl Beardsley								DATE SIGNED June 4, 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 6, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	22d. LOCATION (City, town, or county) Salisbury, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE JUN 9 '58	24b. REGISTRAR'S SIGNATURE <i>John L. Schaefer</i>				

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM P/55

CERTIFICATE OF DEATH

Name of deceased		Age at time of death	
John Doe		80 years	
Sex		Race	
Male		White	
Cause of death		Date of death	
Diseased heart		December 12, 1958	
Place where deceased resided		Date of report	
Milwaukee, Wisconsin		December 13, 1958	
Name and address of physician		Name and address of hospital	
Dr. John Doe, Milwaukee, Wisconsin		Milwaukee General Hospital, Milwaukee, Wisconsin	
Name and address of funeral director		Name and address of coroner	
John Doe, Milwaukee, Wisconsin		Milwaukee County Coroner, Milwaukee, Wisconsin	
Signature of reporter		Signature of physician	
John Doe		John Doe	
Signature of reporter		Signature of coroner	
John Doe		John Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7403

CERTIFICATE OF DEATH

07411

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by
 page 3 should be detached for use as the burial-trouvé permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL		d. STREET ADDRESS 403 MARKET ST.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>Baby girl</i>	Middle <i>NELSON</i>	Last	4. DATE OF DEATH	Month JUNE	Day 1	Year 1958			
5. SEX FEMALE		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 1 1958		9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 59	Hours 4	Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME ROLLIE J. NELSON		14. MOTHER'S MAIDEN NAME ELLA MAE WRIGHT									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rollie Nelson, Snow Hill Md		Address 403 W. Market St.		INTERVAL BETWEEN ONSET AND DEATH 5 hours			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Homicide DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 611		20f. (City or town) 611		(County) 611	(State) 611		
21. I certify that I attended the deceased from 6/1/58 to 6/1/58 , that I last saw the deceased alive on 6/1/58 , and that death occurred at 7:17 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 707 Condor Ave DATE SIGNED 6/1/58 ACTUAL SIGNATURE <i>Bill Gunderson</i> PHYSICIAN'S NAME (Type) <i>Bill Gunderson</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1958		22c. NAME OF CEMETERY OR CREMATORIUM W.L. Fox Baptist Cemetery		22d. LOCATION (City, town, or county) Snow Hill Maryland		(State) 611			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Norman J. Dennis</i>		ADDRESS <i>Snow Hill Md</i>		24a. REC'D BY REGISTRAR DATE JUN 3 '58		24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>					

CERTIFICATE OF DEATH

NAME OF DECEASED		NAME OF DOCTOR	
JAMES LEE KELLY		DR. RICHARD W. COOPER	
ADDRESS		ADDRESS	
1100 KAHANAMOKU		1100 KAHANAMOKU	
HONOLULU, HAWAII		HONOLULU, HAWAII	
AGE		AGE	
50		50	
SEX		SEX	
MALE		MALE	
MATERIAL TESTED		TESTS	
BLOOD		BLOOD	
TIME OF DEATH		TIME OF DEATH	
11:00 A.M.		11:00 A.M.	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
TIME OF DEATH		TIME OF DEATH	
11:00 A.M.		11:00 A.M.	
DEATH CERTIFIED		DEATH CERTIFIED	
BY DR. RICHARD W. COOPER		BY DR. RICHARD W. COOPER	
SIGNATURE		SIGNATURE	
DR. RICHARD W. COOPER		DR. RICHARD W. COOPER	
DATE		DATE	
MAY 1968		MAY 1968	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Wicomico MARYLAND		a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Jesterville		Life time	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Home		R F D	
3. NAME OF DECEASED (Type or print)		First	Middle
Robert		M.	Nutter
4. DATE OF DEATH		Month	Doy
6-6-58		Year	19
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		C	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days
2/5/98		59 yrs.	10 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Waterman		Oysterman	Mass Island
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.		Sidney Nutter	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
Miriah Conway		No	
16. SOCIAL SECURITY NO.		17. INFORMANT	Address
—		Willie Nutter, Jesterville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Buncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Carcinoma of Pancreas</u> DUE TO (c) <u>General abdominal metastasis</u>			
INTERVAL BETWEEN ONSET AND DEATH 27 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		DATE SIGNED 6-9-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/58	22c. NAME OF CEMETERY OR CREMATORIAL Jesterville Cemetery
22d. LOCATION (City, town, or county) Jesterville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cornelia St. John, Bishop, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 13 '58
			24b. REGISTRAR'S SIGNATURE <i>Deborah</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07413

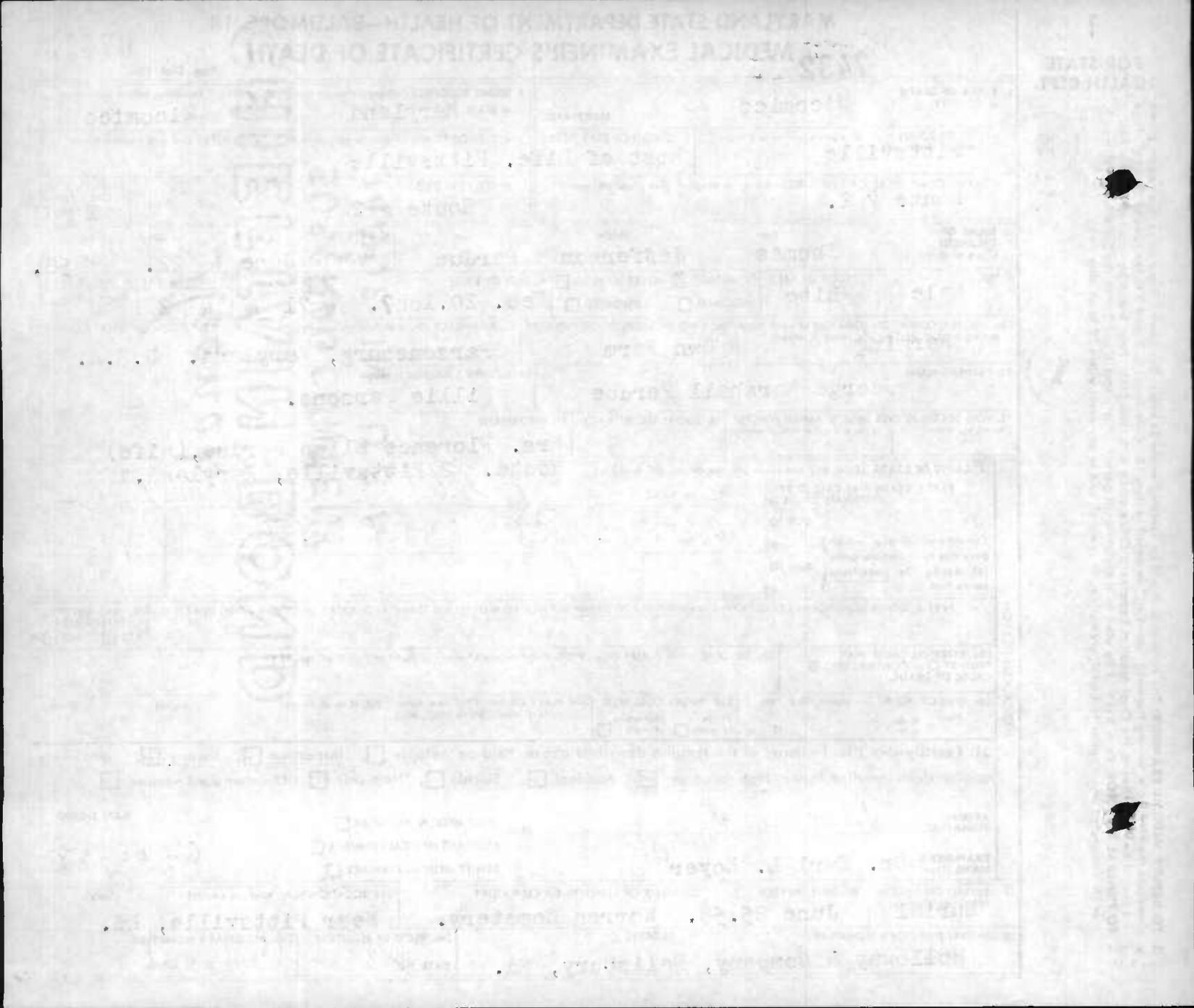
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

7432

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY	Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Pittsville	c. LENGTH OF STAY IN 1b Most of Life.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 2.		d. STREET ADDRESS Route # 2	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Jefferson	Last Perdue	4. DATE OF DEATH Month June Day 22. Year 19 58.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20. 1887.	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 4 Days 2 Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during month of death, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Parsonsburg, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Marshall Perdue		14. MOTHER'S MAIDEN NAME Millie Parsons.		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Florence Ellen Perdue, (Wife) Route. #2 Pittsville, Maryland.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 6-23-58		
EXAMINER'S NAME (Type) Dr. Earl L. Royer	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 25.58.	22c. NAME OF CEMETERY OR CREMATORIUM Warren Cemetery.	22d. LOCATION (City, town, or county) Near Pittsville, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company, Salisbury, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 24 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. Smith</i>			
V.S. AISME SM 2/57						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7404

CERTIFICATE OF DEATH

07414

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY

Wicomico

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE

Madison

b. COUNTY

Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL

and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

MINUTES.

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Peninsula General Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Lewes

Delaware

23423

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

JUNE 17, 1891

9. AGE (In years
lost birthday)
yrs.

66

10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ALONZO G. PAYNE

14. MOTHER'S MAIDEN NAME

EFFIE TOWNSEND

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ASA F. PILCHARD

Address

Pocomoke City, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Myocardial Infarct, acute, cardiac

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While Not while
of work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6-13, 1958 to 6-13, 1958, that I last saw the deceased
alive on 6-13, 1958, and that death occurred at 10 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Walter Ellis, Jr. M.D. 6-13-58

PHYSICIAN'S
NAME (Type)

Walter Ellis, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

6-15-58

22c. NAME OF CEMETERY OR Crematory

GOODWILL METHODIST

22d. LOCATION (City, town, or county)

RURAL

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Henry W. Watson

ADDRESS

Pocomoke, MD.

24a. REC'D BY REGISTRAR

Date JUN 17 '58

24b. REGISTRAR'S SIGNATURE

DeLoach

CERTIFICATE OF DEATH

NAME OF DECEASED	
MORTON LEE COOPER	
ADDRESS	
1000 W. 10TH ST. KANSAS CITY, MO.	
CITY, STATE, ZIP CODE	
KANSAS CITY, MO. 64101	
AGE AT DEATH	
60	
SEX	
MALE	
RACE	
WHITE	
CAUSE OF DEATH	
HEART DISEASE	
TIME AND PLACE OF DEATH	
10:00 AM, KANSAS CITY, MO.	
TIME AND PLACE OF BURIAL	
10:30 AM, KANSAS CITY, MO.	
BAPTIST CHURCH	
NAME OF FUNERAL DIRECTOR	
WILLIAM H. COOPER	
ADDRESS OF FUNERAL DIRECTOR	
1000 W. 10TH ST. KANSAS CITY, MO.	
PHONE NUMBER	
816-231-1234	
DATE OF DEATH	
JULY 10, 1980	
DATE OF CERTIFICATE	
JULY 10, 1980	
SIGNATURE	
WILLIAM H. COOPER	
FINGERPRINTS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07415

7405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanover</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Hanover</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		d. STREET ADDRESS <i>Federal St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Richard</i>	Middle <i>C.</i>	Last <i>Poole</i>	4. DATE OF DEATH Month <i>June</i>	Day <i>14</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 12 1899</i>		9. AGE (In years at birthday) <i>58 7/2</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>14</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plant Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>		11. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>		12. CITIZEN OF WHAT COUNTRY? <i>New Rochelle</i>	
13. FATHER'S NAME <i>Richard Poole</i>		14. MOTHER'S MAIDEN NAME <i>Ashley Purdy</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>087-05-3662</i>		17. INFORMANT <i>Richard C. Poole Jr.</i>		18. ADDRESS <i>50 Diavenport Ave New Rochelle NY</i>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		ACUTE CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH <i>2 HR.</i>	
CORONARY ATHEROSCLEROSIS						5 YR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 14</u> , 1958, to <u>JUNE 14</u> , 1958, that I last saw the deceased alive on <u>JUNE 14</u> , 1958, and that death occurred at <u>1140 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert C. La Mar</i>		ADDRESS (Street, city or town, state) <i>Bay St., Snow Hill, Md.</i>					
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M. D.</i>		DATE SIGNED <i>6-16-58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>June 18/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Pen Cliff</i>		22d. LOCATION (City, town, or county) (State) <i>Hartford, N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Norman J. Dennis</i>		ADDRESS <i>Snow Hill Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE <i>Alfred Green</i>	

STATE OF CALIFORNIA - DEPARTMENT OF CORRECTIONS AND REHABILITATION
CERTIFICATE OF DEATH

DEATH ROW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07416

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7433		CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke-City		c. LENGTH OF STAY IN 1b 4-YEARS		a. STATE VIRGINIA - Accomack		b. COUNTY													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MRS-BEDDING-REST-HOME		e. STREET ADDRESS SUSTIS -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ONANEOCK		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) LENORA		First Amos	Middle RAYFIELD	Lost	4. DATE OF DEATH JUNE - 4th 1958	Month JUNE	Day 4	Year 1958											
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JAN-30-1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ✓		11. BIRTHPLACE (State or foreign country) ONANEOCK - VA		12. CITIZEN OF WHAT COUNTRY? U-S-A.													
13. FATHER'S NAME Lorenzo D. Killmon		14. MOTHER'S MAIDEN NAME Ruth - H. Killmon																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT		Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2												few hours							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Tuberculosis Degenerative Heart Disease												years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nerve palsy, left, following Cerebral Hemorrhage 5 years ago												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 1b.) 19																	
20c. TIME OF INJURY Hour o. p. p. m.		Month Jun	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 307 Market St., Pocomoke City, MD	20f. (City or town) ONANEOCK	(County) VA	(State) MD											
21. I certify that I attended the deceased from June 4, 1958 to June 15, 1958 , that I last saw the deceased alive on June 4, 1958 , and that death occurred at 6 a.m. from the causes and on the date stated above.												ADDRESS (Street, city or town, state) Charles W. Trader, MD, Pocomoke City, MD							
ACTUAL SIGNATURE Charles W. Trader, MD												DATE SIGNED 6-6-58							
PHYSICIAN'S NAME (Type) Charles W. Trader, MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF JUNE-6-1958		22c. NAME OF CEMETERY OR CREMATORIAL Holy		22d. LOCATION (City, town, or county) ONANEOCK-VA		(State) VA	
23. FUNERAL DIRECTOR'S SIGNATURE Fox & Kehlman - ONANEOCK-VA		ADDRESS 101 Main Street, Pocomoke City, MD										24a. REC'D BY REGISTRAR John Fox		24b. REGISTRAR'S SIGNATURE John Fox					
TS RELEASED		DATE 10-10-59										DATE 10-10-59		DATE 10-10-59					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7406 CERTIFICATE OF DEATH

Reg. Dist. No. 07417

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OCEAN CITY</i>		d. STREET ADDRESS <i>PHILADELPHIA A.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>				d. STREET ADDRESS <i>PHILADELPHIA A.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Rose</i>	Middle <i>TILLMAN</i>	(Riley) <i>RILLEY</i>	4. DATE OF DEATH <i>JUNE 3, 1958</i>	Month <i>JUNE</i>	Day <i>3</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>JAN. 27, 1896</i>	9. AGE (In years lost birthday) <i>62 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>HENDERSON, KENTUCKY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>GEORGE CUNNINGHAM</i>		14. MOTHER'S MAIDEN NAME <i>ANN HOLLAND.</i>				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>		17. INFORMANT <i>JAMES PRICE</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Degenerative Heart Disease, unknown</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>6-3, 1958</i> , to <i>6-3, 1958</i> , that I last saw the deceased alive on <i>6-3, 1958</i> , and that death occurred at <i>98</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Salembury, Md.</i>						
ACTUAL SIGNATURE <i>John E. Price</i>		DATE SIGNED <i>6-9-58</i>						
PHYSICIAN'S NAME (Type) <i>Anna R. Burbage</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/9/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. PAULS</i>		22d. LOCATION (City, town, or county) <i>BALTIMORE</i> (State) <i>M.D.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna R. Burbage</i>		ADDRESS <i>Baltimore, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 11 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. eudieh</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07418

7434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTRY Baltimore City	
c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 1422 Madison Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Roosevelt	Middle Ringgold	Last June 12 1958
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1902
9. AGE (In years less birthday yrs.) 55	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY Hospital orderly	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Ringgold		14. MOTHER'S MAIDEN NAME Susan Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 216-09-9474	
17. INFORMANT Deer's Head Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5½ months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958, to June 12, 1958, that I last saw the deceased alive on June 12, 1958, and that death occurred at 1:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. V. Juerman		ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland DATE SIGNED 6/12/58	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cem.		22d. LOCATION (City, town, or county) Ann Arundel County Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE G. Halsted 918 Droid Hill Ave.		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
		24b. REGISTRAR'S SIGNATURE A. Schaeffer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7407

CERTIFICATE OF DEATH

07419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Wicomico MARYLAND		a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Salisbury		X Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Pen Gen. Hospital		Mt Hermon Rd. (POB#590)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JEANNE	Middle PATRICIA
4. DATE OF DEATH		Month JUNE	Doy 14 th Year 1958
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 16, 1957		9. AGE (In years at birthday) 1 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Rev. Harvey L. Sander,		14. MOTHER'S MAIDEN NAME Dorothy Lee Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Rev. Harvey Louis Sander (Father) Mt. Hermon Rd. - POB#590 Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 085.0		Eryphalikos	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Complication of Measles	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 2130 Rue		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/13/58, 19, to 6/14/58, 19, that I last saw the deceased alive on 6/14/58, 19, and that death occurred at 6:25 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 226 N. Division St DATE SIGNED 6/14/58	
ACTUAL SIGNATURE CARRIE I HEARN M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial June 17, 1958 Mansfield Cemetery	
PHYSICIAN'S NAME (Type) CARRIE I HEARN		22d. LOCATION (City, town, or county) Mansfield, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 18 '58	
		24b. REGISTRAR'S SIGNATURE Carrie I. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	65	M	CHRONIC RHEUMATIC HEART DISEASE
ADDRESS	AGE AT DEATH	TIME OF DEATH	PLACE OF DEATH
100 E. 10TH ST., NEW YORK CITY	65	10:00 P.M.	HOSPITAL
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. JAMES M. COOPER, 100 E. 10TH ST., NEW YORK CITY	COOPER FUNERAL HOME, 100 E. 10TH ST., NEW YORK CITY		
NAME AND ADDRESS OF ATTENDING NURSE	NAME AND ADDRESS OF PERSON PREPARING BODY		
MISS MARY COOPER, 100 E. 10TH ST., NEW YORK CITY	MISS MARY COOPER, 100 E. 10TH ST., NEW YORK CITY		
NAME AND ADDRESS OF PERSON MAKING CERTIFICATION	NAME AND ADDRESS OF PERSON SIGNING CERTIFICATE		
DR. JAMES M. COOPER, 100 E. 10TH ST., NEW YORK CITY	DR. JAMES M. COOPER, 100 E. 10TH ST., NEW YORK CITY		
DATE OF DEATH	TIME OF DEATH	PLACES OF DEATH	
DECEMBER 20, 1948	10:00 P.M.	HOSPITAL	
NAME OF PERSON SIGNING CERTIFICATE	DR. JAMES M. COOPER		
ADDRESS OF PERSON SIGNING CERTIFICATE	100 E. 10TH ST., NEW YORK CITY		
PHONE NUMBER	2-1111		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7408

CERTIFICATE OF DEATH

Reg. Dist. No.

07420

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Remberton -Spring Hill Road		d. STREET ADDRESS -Pemberton- Spring Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle GUNBY	Last SEABREASE	4. DATE OF DEATH JUNE	Month 10	Day th 19	Year 58
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 11, 1902	9. AGE (in years last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-Owner-Hardware Store		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME A. Lake Seabrease		14. MOTHER'S MAIDEN NAME Alfonsoa Elliott						
15. WAS EVER ENLISTED IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Anna E. Seabrease (Wife) Address Spring Hill Road-Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic heart disease (c)		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH short				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 5-13, 1955, to 6-10, 1958, that I last saw the deceased alive on 6-10, 1958, and that death occurred at 5:00 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Earl L. Royer M.D.								ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type)		Dr. Earl L. Royer 407 Camden Ave. Salisbury, Maryland						DATE SIGNED June 10 /58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE Owen J. Edwards		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

1898

Date of Birth

Name of Deceased

Cause of Death

Date of Death

Sex

Age

Race

Color

Marital Status

Occupation

Employment

Employer

Address

City

State

Country

Place of Birth

State

Country

Place of Death

State

Country

Place of Burial

State

Country

Burial Method

Burial Location

Burial Date

Burial Time

Burial Service

Burial Clergy

Burial Services

1

**FOR STATE
HEALTH DEPT.**

M

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

REGISTRATION: File page 1 and 2 with the State Board of Health.

ITEMS 20-21 Film 250 6-1-58 amb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07421

Reg. Dist. No.

7435

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hill		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sandy Hill Beach		d. STREET ADDRESS 412 Mitchell St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First AVERY	Middle CRAWFORD	Last SHOCKLEY	4. DATE OF DEATH Month June	Day 1 st
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 19, 1930	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chicken		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland	
13. FATHER'S NAME Avery C Shockley		14. MOTHER'S MAIDEN NAME Mary E. Phillips		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary E. Shockley (Mother) 412 Mitchell St., Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8					
DUE TO Drowning					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from boat to go swimming - Sank, and body not recovered for 4 days			
20c. TIME OF INJURY Hour a. m. p.m. 6-1-58 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nanticoke River	20f. (City or town) nr. Sandy Hill	(County) Kd.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Philip A. Insley</i>	EXAMINER'S NAME (Type) Dr. Philip A. Insley		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 6-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 7 /58	22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery	22d. LOCATION (City, town, or county) R.D. # Salisbury, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR JUN 10 1958	24b. REGISTRAR'S SIGNATURE <i>John L. Rush</i>	DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shown detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7409

CERTIFICATE OF DEATH

07422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VIRGINIA		b. COUNTY ACCOMACK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WITHAMS		d. STREET ADDRESS 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General HOSP.		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle S.	Last Smith	4. DATE OF DEATH June 11 1958	Month Day Year	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 1, 1873	9. AGE (in years from birthday) 84 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CUSTIS SMITH		14. MOTHER'S MAIDEN NAME UNKNOWN		Address C. STANLEY SMITH, WITHAMS, VA.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT C. STANLEY SMITH		INTERVAL BETWEEN ONSET AND DEATH Unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X <i>Arteriosclerosis, Cerebral</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>(Probable) Cerebral Hemorrhage</i> 24h							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Septicemia, Osteomyelitis feet							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jenkins	(County) Bridge	(State) Virginia	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 4 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE David J. Gilmore M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED June 12, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-14-58	22c. NAME OF CEMETERY OR CEMETORY SMITH Family	22d. LOCATION (City, town, or county) JENKINS BRIDGE, VIRGINIA			
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson, Accomack Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE Alv. Beouch		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07423

7410

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		COUNTRY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 32 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		d. STREET ADDRESS 310 Middle Blvd.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Middle Blvd.,				d. STREET ADDRESS 310 Middle Blvd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANCES	Middle WHITE	Last SMITH	4. DATE OF DEATH	Month 6	Day 8	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wm. James White		14. MOTHER'S MAIDEN NAME Georgia Ruark		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. T. Smith, Sr. Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE W. B. Smith		M.D. Salisbury, Maryland						6/9/58	
PHYSICIAN'S NAME (Type) Dr. William B. Smith		Medical Center Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman T. Baker						24a. REC'D BY REGISTRAR DATE JUN 11 1958	24b. REGISTRAR'S SIGNATURE W. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland			d. STREET ADDRESS R F D # 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home R F D # 1									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)		First Ernest	Middle Rufus	Last Stanford	4. DATE OF DEATH Month 6	Day 8	Year 19 58
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5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
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13. FATHER'S NAME William Stanford	14. MOTHER'S MAIDEN NAME Henrietta Banks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT Address Elva Gault, R F D # 1, Salisbury, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerotic cardio-vascular disease Years. DUE TO (c)		
INTERVAL BETWEEN ONSET AND DEATH Sudden		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE *Earl L. Royer* DATE SIGNED **6-10-58**
EXAMINER'S NAME (Type) **Earl L. Royer, M.D.**
M.D. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/11/58	22c. NAME OF CEMETERY OR CREMATORIUM MT. CALVERY	22d. LOCATION (City, town, or county) FRUITLAND MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton F. Stewart</i>	ADDRESS West ROAD	24a. REC'D BY REGISTRAR JUN 12 '58	24b. REGISTRAR'S SIGNATURE Albert J. Coon

STATEMENT OF THE STATE OF TEXAS
EXAMINER'S CERTIFICATE OF DATA

HEDWIGE EDDIE
VIA CO.

STATE



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7411

CERTIFICATE OF DEATH

Reg. Dist. No. 07425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Worcester</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BERLIN</i>		d. STREET ADDRESS <i>BAY STREET</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Charles Henry TURNER</i>		First	Middle	Last	4. DATE OF DEATH <i>June 17 1958</i>	Month	Day	Year				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 13, 1877</i>		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) <i>PAINTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>BERLIN MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Capt. Sesse TURNER</i>		14. MOTHER'S MAIDEN NAME <i>CATHGRINE GRIFFIN</i>		Address								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mr. Floyd TURNER, Salisbury MD.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Acute Staphylococcal Enteritis, Carcinoma of Prostate</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>5/21 1958</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pine Bluff Road, Berlin</i>	20f. (City or town) <i>Berlin</i>	(County) <i>Worcester</i>	(State) <i>MD.</i>
21. I certify that I attended the deceased from <i>June 17, 1958</i> , to <i>6/17, 1958</i> , that I last saw the deceased alive on <i>June 17, 1958</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Pine Bluff Road, Berlin, Md.</i>				DATE SIGNED <i>June 18, 1958</i>						
ACTUAL SIGNATURE <i>Thomas C. Neely Jr.</i>		M.D.										
PHYSICIAN'S NAME (Type) <i>Ames A. Burley Berlin Md</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/19/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen</i>		22d. LOCATION (City, town, or county) <i>Berlin</i>		(State) <i>MD.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ames A. Burley Berlin Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUN 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>						

第十一章 中国古典文学名著与现代文化

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07426

7412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN lb 12	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hosp.	d. STREET ADDRESS 106 Tilghman St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LARRY CLINTON WARD	First LARRY	Middle CLINTON	Last WARD
4. DATE OF DEATH JUNE 17 th 1958	Month JUNE	Day 17	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture	11. BIRTHPLACE (State or foreign country) R.D.# Delaware
13. FATHER'S NAME Elijah Burton Ward		14. MOTHER'S MAIDEN NAME Lula Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 123-45-6789	17. INFORMANT Mrs. Nora Ward (Wife)
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 17 yrs	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 13, 1958 , to June 17, 1958 , that I last saw the deceased alive on June 17, 1958 , and that death occurred at 5:08 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E.P. Ritchings M.D. PHYSICIAN'S NAME (Type) E.P. Ritchings		ADDRESS (Street, city or town, state) Pine Bluff State Hospital Salisbury, Md. DATE SIGNED June 17, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun 20, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery	22d. LOCATION (City, town, or county) Salisbury, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D. BY REGISTRAR JUN 20 1958 DATE
		24b. REGISTRAR'S SIGNATURE John Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7413

CERTIFICATE OF DEATH

Reg. Dist. No.

07427

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4													
may be retained by the hospital or attending physician.													
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.													
1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury		c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pocomoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Peninsula General Hospital		d. STREET ADDRESS		R.F.D. #2 Box 133		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Edith	Middle	Last Waters	4. DATE OF DEATH	Month June	Day 29	Year 1958					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years from last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
Female		Negro				Mar. 23, 1906 52 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during post of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Secretary		Shoe Repair		Maryland		USA							
13. FATHER'S NAME		John E. Waters		14. MOTHER'S MAIDEN NAME		Florence G. Waters							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No				John E. Waters		Pocomoke City, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Necrosis						1 day					
203X		DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Bronchial pneumoniat Pulmonary Edem. 3 day											
{		DUE TO		(c) Multiple Myeloma									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
1491X													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)					
21. I certify that I attended the deceased from May 24, 1958, to 6-29-1958, that I last saw the deceased alive on 6-29-1958, and that death occurred at 4:30 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 6-29-58					
ACTUAL SIGNATURE Frank E. Poole		M.D.		111 Davis Street									
PHYSICIAN'S NAME (Type) Frank E. Poole				Salisbury, Md.									
22a. BURIAL, CREMATION REMOVAL (Specify) Brynia		22b. DATE THEREOF 7/3/68		22c. NAME OF CEMETERY OR CREMATORIUM Unionville Cem.		22d. LOCATION (City, town, or county) Pocomoke City, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton		ADDRESS New Church, Va.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arv. Leach					
						DATE JUL 7 '58							

CERTIFICATE OF DEATH

REF ID: GAX133

Medio Mar 33, 1980 25

A2. N

Secretary State, Moldova

Topu E. Motocycles Co., Moldova

NO

Topu E. Motocycles Co., Moldova

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8, see: Birth Cert. et

07428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R F D # 13	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael		First White	Middle White
4. DATE OF DEATH 6-5-58	Month 6	Day 5	Year 19
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1956
			9. AGE (In years last birthday) 1 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Joan White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO. 835X	
17. INFORMANT Guilene White		Address Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Crushed chest.		INTERVAL BETWEEN ONSET AND DEATH udden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 835X			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child backed over by grandfather by car.	
20c. TIME OF INJURY Hour 5:10 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
Month, Day, Year 6-5-58		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of home.	
		20f. (City or town) Fruitland	
		(County) Wicomico	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 6-10-58	
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-58	
22c. NAME OF CEMETERY OR CREMATORIAL Eden Cem		22d. LOCATION (City, town, or county) Eden Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Beaker Welch</i>		ADDRESS ADDRESS	
		24a. REGD. BY REGISTRAR JUN 12 1958	
		24b. REGISTRAR'S SIGNATURE W. Welch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

STATE OF OHIO
DEPARTMENT OF STATE
REGISTRATION OF TRADE NAMES

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7437

CERTIFICATE OF DEATH

Reg. Dist. No.

07429

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS 10 Columbia Avenue				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas J. Whittington		First	Middle	Lost	4. DATE OF DEATH June 10 1958	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1866	9. AGE (in years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Whittington		14. MOTHER'S MAIDEN NAME Virginia Stevenson		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No UNK		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, Salisbury, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						Years				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED p. m. While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 58 , to June 10 , 19 58 , that I last saw the deceased alive on June 10 , 19 58 , and that death occurred at 8:50A M , from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. Kosmahl</i>		M.D. Dear's Head State Hospital		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 6/10/58				
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		22d. LOCATION (City, town, or county) Crisfield, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE <i>Abdullah</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. *Leucosia* *leucostoma* *leucostoma* *leucostoma*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

M

82

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07431
7416 CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb 1-Hr.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 SALISBURY		d. STREET ADDRESS 1 709 Alvin Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) ORGANIZATION- PENINSULA GEN. Hosp.										
3. NAME OF DECEASED (Type or print)		First FLORENCE	Middle Wingate	Last WILLIAMS	4. DATE OF DEATH Month 6 Day 12 Year 1958					
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 27, 1900		9. AGE (In years from birthday) yrs. 38		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ALBERT LEE WINGATE		14. MOTHER'S MAIDEN NAME MARY E. Smith								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-34-7723		17. INFORMANT J. HERMAN WILLIAMS - SAME		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Acute Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Coronary Artery Disease			8 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Maryland	(State) Md.	
21. I certify that I attended the deceased from Aug , 1957, to Aug 12 , 1958, that I last saw the deceased alive on June 12, 1958 , and that death occurred at 3:30 AM , from the causes and on the date stated above.										
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D. ADDRESS (Street, city or town, state) SALISBURY MARYLAND DATE SIGNED 6/12/58										
PHYSICIAN'S NAME (Type) Thomas C. Hill, Jr.		224 N. DIXIE PINE BLUFF RD.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/13/1958		22c. NAME OF CEMETERY OR CREMATORIAL PARSONS CEMETERY		22d. LOCATION (City, town, or county) Salisbury		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co.		ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE Albert Johnson				
Signature George C. Stepp II										

BY ENDOWMENT - READING FROM THE STATE CIRCUIT RAIL

ROUTE NO. 12 STATE ROAD

ROUTE 12



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Wicomico MARYLAND		Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb X Willards	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Zadeck		First B	Middle Williams
Last		4. DATE OF DEATH 6- 3 1958	Month Day Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 4 1902
		9. AGE (in years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwork		10b. KIND OF BUSINESS OR INDUSTRY Millwork	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? 21. S.			
13. FATHER'S NAME Isaac Williams		14. MOTHER'S MAIDEN NAME Anna Dawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Margaret Revel - Delmar - Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to severed right iliac vessels-Sudden			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by a truck.	
20c. TIME OF INJURY Month, Day, Year 10:30 a.m. M. 6-3-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) RFD #30		20f. (City or town) (County) (State) Willards Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		DATE SIGNED 6-3-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, ETC., DATE THEREOF REMOVAL (Specify) 6/5/58		22c. NAME OF CEMETERY OR CREMATORIAL Willards Cemetery	
22d. LOCATION (City, town, or county) Willards		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald James - Willards - Del.		24a. FEED BY REGISTRAR DATE JUN 9 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. Schuch	

STATE OF MONTANA DEPARTMENT OF LABOR
MIGRANT EXAMINER'S CERTIFICATE

Montana

Montana

Montana

Montana State Board of Education

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07433

7418

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		1. PLACE OF DEATH a. COUNTY Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	b. COUNTY Wicomico
82		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	c. LENGTH OF STAY IN 1b 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	d. STREET ADDRESS 523 CARRELTON AVE
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3.		NAME OF DECEASED (Type or print) First	Middle	Last WILSON	4. DATE OF DEATH Month JUNE Day 19 Year 1958
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1958	9. AGE (In years lost birthday) yrs. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? Usd.	
13. FATHER'S NAME Donald Wilson		14. MOTHER'S MAIDEN NAME Nellie Karsia	Address Donald Wilson Salisbury Md		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Donald Wilson Salisbury Md	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Atelectasis DUE TO (c) Pneumonia	
				INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County) (State) Wicomico Md
21. I certify that I attended the deceased from 6/17 , 1958, to 6/19 , 1958, that I last saw the deceased alive on 6/19 , 1958, and that death occurred at 4:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE William C. Morgan		ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 6/19/58			
PHYSICIAN'S NAME (Type) William C. Morgan					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2019	22c. NAME OF CEMETERY OR CREMATORIUM Oriele	22d. LOCATION (City, town, or county) Oriele Md.	(State) MD
23. FUNERAL DIRECTOR'S SIGNATURE James L. Morgan		ADDRESS 100 Princess Lane, No. 2082282XV2	24a. REC'D BY REGISTRAR DATE JUN 30 '58		
			24b. REGISTRAR'S SIGNATURE John C. Morgan		

1. BROWNSTONE STATION TO THE NARROWS STATE PARK